

A bill for an act

relating to health; modifying the provider peer grouping timelines and system; adding provision to agricultural cooperative health plan for farmers; requiring reports; amending Minnesota Statutes 2008, sections 62U.04, subdivisions 3, 9; 256B.0754, subdivision 2; Laws 2007, chapter 147, article 12, section 14; repealing Minnesota Statutes 2009 Supplement, section 256B.032.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2008, section 62U.04, subdivision 3, is amended to read:

Subd. 3. **Provider peer grouping.** (a) The commissioner shall develop a peer grouping system for providers based on a combined measure that incorporates both provider risk-adjusted cost of care and quality of care, and for specific conditions as determined by the commissioner. In developing this system, the commissioner shall consult and coordinate with health care providers, health plan companies, state agencies, and organizations that work to improve health care quality in Minnesota. For purposes of the final establishment of the peer grouping system, the commissioner shall not contract with any private entity, organization, or consortium of entities that has or will have a direct financial interest in the outcome of the system.

(b) ~~Beginning June 1~~ By no later than October 15, 2010, the commissioner shall disseminate information to providers on their total cost of care, total resource use, total quality of care, and the total care results of the grouping developed under this subdivision in comparison to an appropriate peer group. Any analyses or reports that identify providers may only be published after the provider has been provided the opportunity by the commissioner to review the underlying data and submit comments. Providers may be given any data for which they are the subject of the data. The provider shall have ~~21~~ 30 days to review the data for accuracy and initiate an appeal as specified in paragraph (d).

(c) By no later than January 1, 2011, the commissioner shall disseminate information to providers on their condition-specific cost of care, condition-specific resource use, condition-specific quality of care, and the condition-specific results of the grouping developed under this subdivision in comparison to an appropriate peer group. Any analyses or reports that identify providers may only be published after the provider has been provided the opportunity by the commissioner to review the underlying data and submit comments. Providers may be given any data for which they are the subject of the data. The provider shall have 30 days to review the data for accuracy and initiate an appeal as specified in paragraph (d).

(d) The commissioner shall establish an appeals process to resolve disputes from providers regarding the accuracy of the data used to develop analyses or reports. When a provider appeals the accuracy of the data used to calculate the peer grouping system results, the provider shall:

(1) clearly indicate the reason they believe the data used to calculate the peer group system results are not accurate;

(2) provide evidence and documentation to support the reason that data was not accurate; and

(3) cooperate with the commissioner, including allowing the commissioner access to data necessary and relevant to resolving the dispute.

If a provider does not meet the requirements of this paragraph, a provider's appeal shall be considered withdrawn. The commissioner shall not publish results for a specific provider under paragraph (e) or (f) while that provider has an unresolved appeal.

~~(d)~~ (e) Beginning September 1, 2010 January 1, 2011, the commissioner shall, no less than annually, publish information on providers' total cost, total resource use, total quality, and the results of the total care portion of the peer grouping process. The results that are published must be on a risk-adjusted basis.

(f) Beginning March 30, 2011, the commissioner shall no less than annually publish information on providers' condition-specific cost, condition-specific resource use, condition-specific quality, and the results of the condition-specific portion of the peer grouping process. The results that are published must be on a risk-adjusted basis.

(g) Prior to disseminating data to providers under paragraph (b) or (c) or publishing information under paragraph (e) or (f), the commissioner shall ensure the scientific validity and reliability of the results according to the standards described in paragraph (h). If additional time is needed to establish the scientific validity and reliability of the results, the commissioner may delay the dissemination of data to providers under paragraph (b) or (c), or the publication of information under paragraph (e) or (f). If the delay is more than

60 days, the commissioner shall report in writing to the Legislative Commission on Health Care Access the following information:

(1) the reason for the delay;

(2) the actions being taken to resolve the delay and establish the scientific validity and reliability of the results; and

(3) the new dates by which the results shall be disseminated.

If there is a delay under this paragraph, the commissioner must disseminate the information to providers under paragraph (b) or (c) at least 90 days before publishing results under paragraph (e) or (f).

(h) The commissioner's assurance of valid and reliable clinic and hospital peer grouping performance results shall include, at a minimum, the following:

(1) use of the best available evidence, research, and methodologies; and

(2) establishment of an explicit minimum reliability threshold developed in collaboration with the subjects of the data and the users of the data, at a level not below nationally accepted standards where such standards exist.

In achieving these thresholds, the commissioner shall not aggregate clinics that are not part of the same system or practice group. The commissioner shall consult with and solicit feedback from representatives of physician clinics and hospitals during the peer grouping data analysis process to obtain input on the methodological options prior to final analysis and on the design, development, and testing of provider reports.

Sec. 2. Minnesota Statutes 2008, section 62U.04, subdivision 9, is amended to read:

Subd. 9. **Uses of information.** (a) By ~~January 1, 2011~~ no later than 12 months after the commissioner publishes the information in subdivision 3, paragraph (e):

(1) the commissioner of management and budget shall use the information and methods developed under subdivision 3 to strengthen incentives for members of the state employee group insurance program to use high-quality, low-cost providers;

(2) all political subdivisions, as defined in section 13.02, subdivision 11, that offer health benefits to their employees must offer plans that differentiate providers on their cost and quality performance and create incentives for members to use better-performing providers;

(3) all health plan companies shall use the information and methods developed under subdivision 3 to develop products that encourage consumers to use high-quality, low-cost providers; and

(4) health plan companies that issue health plans in the individual market or the small employer market must offer at least one health plan that uses the information

developed under subdivision 3 to establish financial incentives for consumers to choose higher-quality, lower-cost providers through enrollee cost-sharing or selective provider networks.

(b) By January 1, 2011, the commissioner of health shall report to the governor and the legislature on recommendations to encourage health plan companies to promote widespread adoption of products that encourage the use of high-quality, low-cost providers. The commissioner's recommendations may include tax incentives, public reporting of health plan performance, regulatory incentives or changes, and other strategies.

Sec. 3. Minnesota Statutes 2008, section 256B.0754, subdivision 2, is amended to read:

Subd. 2. **Payment reform.** By ~~January 1, 2011~~ no later than 12 months after the commissioner of health publishes the information in section 62U.04, subdivision 3, paragraph (e), the commissioner of human services shall use the information and methods developed under section 62U.04 to establish a payment system that:

- (1) rewards high-quality, low-cost providers;
- (2) creates enrollee incentives to receive care from high-quality, low-cost providers;
- and
- (3) fosters collaboration among providers to reduce cost shifting from one part of the health continuum to another.

Sec. 4. Laws 2007, chapter 147, article 12, section 14, is amended to read:

Sec. 14. **AGRICULTURAL COOPERATIVE HEALTH PLAN FOR FARMERS.**

Subdivision 1. **Pilot project requirements.** Notwithstanding contrary provisions of Minnesota Statutes, chapter 62H, the following apply to a joint self-insurance pilot project administered by a trust sponsored by one or more agricultural cooperatives organized under Minnesota Statutes, chapter 308A or 308B, or under a federal charter for the purpose of offering health coverage to members of the cooperatives and their families, provided the project satisfies the other requirements of Minnesota Statutes, chapter 62H:

- (1) Minnesota Statutes, section 62H.02, paragraph (b), does not apply;
- (2) the notice period required under Minnesota Statutes, section 62H.02, paragraph (e), is 90 days;
- (3) a joint self-insurance plan may elect to treat the sale of a health plan to or for an employer that has only one eligible employee who has not waived coverage as the sale of an individual health plan as allowed under Minnesota Statutes, section 62L.02, subdivision 26;

(4) Minnesota Statutes, section 297I.05, subdivision 12, paragraph (c), applies; and  
(5) the trust must pay the assessment for the Minnesota Comprehensive Health Association as provided under Minnesota Statutes, section 62E.11.

**Subd. 2. Evaluation and renewal.** The pilot project authorized under this section is for a period of four years from the date of initial enrollment. The commissioner of commerce shall grant an extension of four additional years if the trust provides evidence that it remains in compliance with the requirements of this section and other applicable laws and rules. If the commissioner determines that the operation of the trust has not improved access, expanded health plan choices, or improved the affordability of health coverage for farm families, or that it has significantly damaged access, choice, or affordability for other consumers not enrolled in the trust, the commissioner shall provide at least 180 days' advance written notice to the trust and to the chairs of the senate and house finance and policy committees with jurisdiction over health and insurance of the commissioner's intention not to renew the pilot project at the expiration of a four-year period.

**Subd. 3. Use of surplus lines.** Plans created under this section may use surplus lines carriers to fulfill its obligations under chapter 62H.

**Sec. 5. PAYMENT REFORM IMPLEMENTATION REPORT.**

By April 1, 2011, the commissioner of human services shall report to the chairs of the senate Health and Human Services Budget Division and the house of representatives Health Care and Human Services Finance Division recommendations for implementing the payment reform in Minnesota Statutes, section 256B.0754, subdivision 2. The recommendations shall include:

- (1) legislative changes needed to fully implement this payment reform; and
- (2) an analysis of the fiscal impact of implementing this payment reform.

**Sec. 6. REPEALER.**

Minnesota Statutes 2009 Supplement, section 256B.032, is repealed.

**256B.032 ELIGIBLE VENDORS OF MEDICAL CARE.**

(a) Effective January 1, 2011, the commissioner shall establish performance thresholds for health care providers included in the provider peer grouping system developed by the commissioner of health under section 62U.04. The thresholds shall be set at the 10th percentile of the combined cost and quality measure used for provider peer grouping, and separate thresholds shall be set for hospital and physician services.

(b) Beginning January 1, 2012, any health care provider with a combined cost and quality score below the threshold set in paragraph (a) shall be prohibited from enrolling as a vendor of medical care in the medical assistance, general assistance medical care, or MinnesotaCare programs, and shall not be eligible for direct payments under those programs or for payments made by managed care plans under their contracts with the commissioner under section 256B.69 or 256L.12. A health care provider that is prohibited from enrolling as a vendor or receiving payments under this paragraph may reenroll effective January 1 of any subsequent year if the provider's most recent combined cost and quality score exceeds the threshold established in paragraph (a).

(c) Notwithstanding paragraph (b), a provider may continue to participate as a vendor or as part of a managed care plan provider network if the commissioner determines that a contract with the provider is necessary to ensure adequate access to health care services.

(d) By January 15, 2013, the commissioner shall report to the legislature on the impact of this section. The commissioner's report shall include information on:

- (1) the providers falling below the thresholds as of January 1, 2012;
- (2) the volume of services and cost of care provided to enrollees in the medical assistance, general assistance medical care, or MinnesotaCare programs in the 12 months prior to January 1, 2012, by providers falling below the thresholds;
- (3) providers who fell below the thresholds but continued to be eligible vendors under paragraph (c);
- (4) the estimated cost savings achieved by not contracting with providers who do not meet the performance thresholds; and
- (5) recommendations for increasing the threshold levels of performance over time.